

IMPACT OF CULTURE ON HEALTH CARE

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Historically, physicians practiced medicine in communities with patients who had similar cultural and racial backgrounds to their own. The racial and ethnic composition of the United States has changed significantly in recent years, and is projected to become even more diverse. According to the United States Census Bureau, African Americans, Hispanics, Asian Americans, Pacific Islanders, and Native Americans are currently 25% of the U.S. population,¹ and this proportion is expected to increase to 36% by the year 2020.² Some areas in the United States will be influenced by these patterns more than other areas.

For example, it is estimated that by 2020 only 33% of the California population will be non-Hispanic whites.³ Plans to care for these ethnically and culturally diverse patients must include providers with an understanding and appreciation of cultural diversity. The following case demonstrates this point.

CASE

Mr. C.R. was a 35-year-old Mexican male immigrant with limited English proficiency who resided in the United States for four years. He initially presented with complaints of frequency, nocturia, hesitancy and suprapubic pain that had been present for several months. A previous physician prescribed an antibiotic for prostatitis. After two weeks, he reported no improvement and sought care from a hospital-based urgent care clinic. During this visit, the physi-

cian documented a boggy, tender prostate, moderately increased blood pressure, and a normal urinalysis, for which he prescribed a different antibiotic for prostatitis. There were no bilingual providers or interpreters at the previous medical encounters.

On his third visit, a Spanish-speaking provider saw the patient. The patient was able to express his concern about his continued symptoms. He was discouraged and tired from interrupted sleep secondary to nocturia. Additionally, he lost his job because he took "too many long bathroom breaks."

Mr. C.R. had been relatively healthy except for a motor vehicle accident 10 years earlier. His injuries included skull, left upper extremity and right lower extremity fractures. He had been hospitalized for a month, during which time he had a urinary catheter in place. Since this time, he reported difficulty voiding, but this improved after taking herbal medicines to "clean his system."

When he came to the United States, he experienced worsening urinary symptoms and sought help from an herbalist. He had taken many different herbal remedies—including cat's claw, horsetail, papaya pills, and corn silk pills. The herbalist also prescribed iridology and reflexology for Mr. C.R. He continued with the herbal medicines, but his symptoms worsened. Under the advice of his herbalist, the patient sought medical treatment.

On physical examination, he appeared fatigued with a flattened affect. His blood pressure was 170/100 in both arms. His neurologic examination was normal. He had a distended bladder on percussion. His laboratory data revealed the following: potassium 5.4, BUN 68, creatinine 6.4, Hematocrit 33. His HIV and RPR were negative. His renal ultrasound revealed bilateral hydronephrosis.

The patient was admitted to the hospital after attempted urethral catheter placement failed. A suprapubic catheter was placed, and the post-void residual was 2.5 liters. The patient agreed to discontinue all herbal medicines only after his herbal-

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ist was in agreement. He was diagnosed with a urethral stricture, possibly resulting from previous trauma. The catheter remained in place for one month. His blood pressure and renal function normalized, and he underwent a surgical procedure to relieve the urethral obstruction. The patient resumed herbal medicines to clean his system, and he is voiding without difficulties.

DISCUSSION

To effectively and efficiently treat patients, we must appreciate the impact that culture has on health care. Culture can be viewed as beliefs, values, and attitudes shared and perpetuated by members of a social group.⁴ Culture is a complex whole that also includes shared traditions, customs, language, and norms that must be learned from families and social communities.⁵ Each medical encounter provides the opportunity for the interface of several different cultures: the culture of the patient, the culture of the physician and the culture of medicine. This interface often influences adherence to medical regimens, patient satisfaction, health care utilization, and health outcomes.

The biomedical aspects of this case present a fairly straightforward case of obstructive uropathy. However, this case also demonstrates several key cultural issues—including language, traditional and herbal medicine, and differing cultural thresholds in seeking health care from physicians versus traditional health care providers and healers.

Language

Language and patterns of communication are key components of culture and can be obstacles in providing good medical care. Health care providers, because of lack of availability or time constraints, may not utilize reliable translation. In this case, on at least two previous occasions, this Spanish-speaking patient had no trained interpreter. The lack of translation resulted in the physician's decreased understanding of symptoms and delayed diagnosis, and the patient's prolonged suffering, increased frustration, and loss of employment.

Approximately 32 million people—nearly 14% of the U.S. population—speak a language other than English in their homes.⁶ The federal government, as a major purchaser of health care and enforcer of civil rights laws, has a large role in ensuring language competence. In fact, the U.S. Department of Health and Human Services Office

for Civil Rights views inadequate interpretation in health care as a form of discrimination.⁷

In spite of this, many health care facilities do not have salaried, professional interpreters available.⁸ Physicians that see patients with limited English are thought to rely heavily on ad hoc interpreters, family members, hospital staff, other patients, or no interpreter at all.

Each of these situations is obviously imperfect and often result in errors in translation. One investigator found that 23% to 52% of physician's questions were mistranslated or not translated at all. The author lists several examples of interpreter errors, including "chest" for "ribs," "neck" for "tonsil," "teeth" for "jaw," "fat" for "swelling," "laxative" for "diarrhea."

Family dynamics also influenced translation. In one example, a child was embarrassed to ask questions regarding menses and bowel movements.⁹ It is easy to imagine that these errors could have potentially significant clinical ramifications.

Alternative Medicine

The use of alternative medicines is another important feature of this case. Complementary and alternative therapies have been defined as practices that are used to prevent or treat illness that are not widely taught in medical schools and are not typically available in hospitals.¹⁰ It has been estimated that 60 million Americans used alternative medical therapies in 1990.¹⁰ The authors of this report conducted telephone interviews of more than 1,500 adults in a national sample and found that more than 70% of the patients that reported using alternative therapies never told their physicians.¹⁰ This frequently unspoken issue may have important implications for patient care.

Smaller studies that have examined the use of alternative therapies, specifically in Mexican Americans, have also found high rates of use. A survey of Mexican families in West Texas showed that 50% used folk medicines. These practices were not influenced by educational level, employment, or primary language.¹¹ Another study interviewed Mexican Americans with Type 2 diabetes and found that herbs were mentioned by 84% of patients as possible alternative treatments for diabetes. Most, however, viewed these as supplements to medical therapy.¹²

Although there is limited data on the safety and efficacy of many of these treatments, it is important to explore their use. Patients may rely on marketing campaigns and anecdotes for justification to try

these new therapies. As physicians, we must be concerned about possible risks related to alternative therapies. Because of less quality control, these therapies may be more likely to have impurities.¹³

For example, L-tryptophan, a synthetic version of the amino acid, was found to have an impurity introduced during the synthetic process that was responsible for over 1,000 cases of eosinophilia-myalgia syndrome, resulting in 38 deaths.¹⁴ These therapies may be toxic alone or in combination with other medications. There are cases of overdose and death related to the use of *Herba ephedra* (herbal ephedrine), also known as *ma huang*.¹⁰ This and other examples make the case for having the discussion with your patients, if only to safeguard them.

Additionally, physician knowledge of the patients' use of these therapies can facilitate responsible use and build partnerships with patients. More than 80% of patients who reported using alternative therapies combined these with conventional medicine.¹⁵ Several authors have found that use of alternative therapies is not confined to patients of any particular social class or to patients who seem to be dissatisfied with or mistrusting of conventional medicine.^{16,17}

Physicians discussing herbal medicines and alternative practices may build trust and facilitate future negotiations if such practices are found to be harmful. In this case, horsetail and cat's claw, for example, have diuretic activity that may have clinical relevance. Even more important, perhaps, is providing an environment in which the patient feels comfortable discussing the use of these therapies, healers, and other traditional medical practices with the physician.

Cultural Aspects of Health Care Seeking Behaviors

This case also demonstrates that seeking care at physicians' offices and hospitals may be viewed as a last option by patients. Patients may seek advice from several sources—including family members, friends, and as in this case, an herbalist. Additionally, many medical symptoms are self-diagnosed and self-treated.¹⁸ Recognizing and addressing previous attempts at treatment can help demonstrate the course of the disease, identify potentially harmful or helpful interventions taken, and build therapeutic alliances.

In this case, rather than disregarding the practices and beliefs of the patient, the physician contacted

the herbalist who was instrumental in maintaining the patient's compliance with the therapeutic regimen. Recognizing that the patient had strong beliefs, acknowledging these beliefs, and incorporating them improved patient satisfaction and trust.

Plans to care for an even more ethnically and racially diverse population must include building cultural competence. This is an ongoing and interactive process, based on appropriate physician knowledge, understanding, and appreciation of cultural distinctions, and the impact this has on health care. Cultural competence is broader than linguistic competence discussed in this case and must go beyond cultural sensitivity and knowledge. It must include having skills and the ability to effectively navigate cross-cultural encounters.

We practice medicine most often from a medicocentric point of view. In our role as physicians, the tradition of medicine and the medical culture often override our own individual cultures when caring for patients. Training to augment our ability to care for our increasingly diverse society should be integrated in medical schools, residency programs and continuing medical education for practicing physicians.

We must be willing to participate in lifelong learning that helps integrate the principles of biomedicine with the many beliefs and values of our patients. We can accomplish this by improving communication, knowledge, and negotiations to reach an agreement for the best medical care possible.

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